DEPARTMENT OF USALS	•		(# - ()	Ø1004/025
CENTERS FOR MEDICARE	AND HUMAN SERVICES	PΟ	c#2	PRINTED: 11/23/2015 FORM APPROVED
TATEMENT OF DEFICIENCES NO FLAN OF CORRECTION	(X1) PROMOERSUPFLIER/OLIA' IDENTIFICATION NUMBER	(X2) MLT.T A. BUA.DE	IPLE CONSTRUCTION NO	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	445174	B, WING		11/10/2015
NAME OF PROVIDER OR SUPPLIER		Ţ.	STREET ADDRESS, CITY, STATE, ZIP CODE	11/10/2018
Brookhaven Manor	·		2036 STONEBROOK PLACE KINGSPORT, IN 37660	
PREFIX FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPRINCED TO THE APPRINCED FOR THE APPRIN	DED RIP CONTRIBUTE
F 157 483.10(b)(11) NOT SS=D (INJURY/DECLINE	IFY OF CHANGES (ROOM, ETC)	F 15	57	12/14/15 Darteof
consult with the reaknown, notify the recordent involving the injury and has the placement injury and has the placement in heal physical, mental, or deterioration in heal status in either life to clinical complication significantly (i.e., a rexisting form of treatment); or a decimination of the deterioration of the consequences, or to treatment); or a decimination of the consequences.	ediately inform the resident; ident's physician; and if sident's legal representative ally member when there is an or resident which results in olential for requiring physician ficant change in the resident's psychosocial status (i.e., a the mental, or psychosocial in the second conditions or is); a need to alter treatment need to discontinue an itemant due to adverse a commence a new form of ision to transfer or discharge e facility as specified in		F157 I. Resident #73 was discharged prior to survey.	Camplionce
and, if known, the representative change in room or manage in room or manage in §483.19 resident rights under regulations as specified in §483.19 resident rights under regulations as specifies section. The facility must recitive address and phologal representative legal representative by: Based on review of review, and interview, and interview.	o promptly notify the resident seldent's legal representative member when there is a commate assignment as 5(e)(2); or a change in Federal or State law or fied in paragraph (b)(1) of ord and periodically update one number of the resident's or interested family member. T is not met as evidenced facility policy, medical record or, the facility failed to notify gnificant change in urinary		II. All residents have the potential to be affected. MDS pulled continence scores of residents for past three mds to determine if any other resident had change in continence requiring physician notification.	

y deficiently statement ending with an asterick (*) denotes a deficiency which the institution may be excised from correcting providing it is determined that or safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 80 days owing the date of autypy whether or not a plan of correction is provided. For nursing fromes, the above indings and plans of correction are disclosable 14 of following the date these documents are made available to the lapthy. If deficiencies are cited, an approved plan of correction is requisite to continued

CM CMS-2567(02-99) Previous Versions Charles

Event ID, 211611

Facility #12 TNB203

If continuation sheet Page 1 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES					PORIL): 11/23/2016 APPROVEC
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDENSUPPLIERICLIA IDENTIFICATION NUMBER:	V BOIT		ECONSTRUCT	ноп	(X3) DA). 0938-0391 TE SURVEY MFLETED
		445174	B. WING	-			1 44	/10/2015
VAME OF I	PROVIDER OR SUPPLIER			5	TREET ADDRE	58, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	102015
BROOKI	IAVEN MANOR	<u> </u>	_		þis etonebi Ingsport,	ROOK PLACE TN 37660		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEPICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING MEORMATION;	ID PRES TAG	X	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIESTICIENCY)	i laid	(PG) COMPLETION DATE
F 157	Continued From pa	ge 1	F -	157				
		for 1 resident (#73) of 2	•		111.	Licensed nursing		İ
	residents reviewed	for urinary incontinence of 35	l			staff in-serviced on		
ı	residents reviewed.		·			11/27/15 on change		1
	The findings include	ed:	i			of condition		
	•		ļ			including MD and		
i		y's policy Change in a	ļ			family notification		
	resident & Congrad revealed. "our fac	n or Status revised 8/2011, ility shall promptly notify the				by the Director of		
	resident, his or her,	Attending Physician, and				Nursing. Nursing		
1	representative (spo	naer) of changes in the	1			supervisor will		•
ľ	resident's medical/r statusA significan	nental condition and/or change in the resident's				•		
	physical/emotional/	mental conditionExcept in				review twenty four		1
	medical emergencia	s, notifications will be made				hour report, adl		
	occurring in the resi	4) hours of a change dent's medical/mental				flow sheets, and		,
· -	condition or status	a medicaliticality				new orders for any		
	kd=-2!		Í			changes in		
.	medical record review	wy revealed Resident #73 was ity on 5/21/15 with diagnoses			•	condition. Nursing		
	of Chronic Airway O	bstruction, Congestive Heart				supervisor will		
	Fallure, Joint Replace	cement Shoulder, Diabetes				conduct these		(`
ĺ	Mellitus Type II, Chr Disease Aprilo Valu	onic Pulmonary Heart			,	reviews Monday		j
	Syndiome, Ostenar	e Disorder, Dysmetabolic thritis, Celiulitis of Leg, Morbid				through Friday		İ
	Obesity, and Depres	ision,				excluding holidays.		ļ
İ	Ravious of the secids	sit's admission Minimum						
	Data Set (MDS) del	ars admission Minimum ad 5/29/15 revealed the			IV.	Nursing supervisor		
	resident's Brief Inter	view for Mental Status (BIMS)				will report to		
	was 15, indicating the	e resident was cognitively		-		Director of Nursing		
	was always contine!	view rovesied the resident				weekly. Weekly		1
ا , ا	-					reports will be taken		
- 1	Medical record revie	w of a facility admission				•		
Ì	bladder evaluation d resident's bladder o	ated 5/21/15 revealed the				to QA monthly.		,
ļ	essessed as comple	ele control. Further review]
-	7(02 -09) Previous Versions (·	Fare	dy ID: TNB203	15	1	
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		AND HUMAN SERVICES					FORM	11/23/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. SULLING					E SURVEY PLETED
	<u></u> .	445174	B. WING	<u></u>			14,	10/2015
	PROVIDER OR SUPPLIER		·	;	STREET ADDRESS 2035 STONEBRO KINGSPORT, T		111/	10/2016
(K4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF OTFICENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	×	PROV (EACH C	IDER'S FLAN OF CORRECTION CORRECTIVE ACTION SHOULD FERENCED TO THE APPROP DEFICIENCY)	BE	(XS) COMPLETION DATE
F 160	during the resident's Review of the facilitiving) Flow Record resident was freque (more than 7 epison 6/7/15. Continued in revealed the reside bladder from 6/8/15 8/26/16. Medical record review Summary dated 6/16 (continent) of B/8 (blacksional incontine Review of the facilitivities dated 6/28/11 revealed the Physic resident's change in Interview with the Different and the nursing assessments and wany decline in the report of the resident's decident's decid	a no other biadder evaluations is stay. y's ADL (activities of delly for 6/2015 revealed the crity incontinent of bladder des) from 8/1/15 through eview of the ADL Flow Record in twas totally incontinent of through discharge on twas totally incontinent of through discharge on ew of a Nursing Weekly /15 revealed, "Cont. owel and bladder] with ent episodes" y MD (Physiclan's) Office of the physiclan is continence status. irector of Nursing (DON) on M, in the DON's office, and staff performed ongoing the to report to the physician esident's bladder function. The resident's bladder function ange in the resident's status if falled to notify the Physician eyANCE OF PERSONAL	F.1		F160	The state of Tennessee treasury on behalf of resident #150 was reimbursed on 11/18/15. All residents have the potential to be affected. Regional accountant audited on 11/17/15 to determine if any other residents affected. No other residents affected by this deficient practice.		12/14/16
206 (20.00.25)	37(02-00) Provious Versions	Obsolete Event ID: 21.1-1111		 E	ENV NOX TIMEZOX	16 continue		

OF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER AVEN MANOR	(X1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER: 445174	A BUILDI	NG	(X3) DATE SURVEY COMPLETED	
AVEN MANOR	445174	B. WING	•	(X3) DATE SURVEY COMPLETED	
AVEN MANOR	· · · · · · · · · · · · · · · · · · ·	1		11/10/2015	
22 L 40 40 20 4 0 20 4			STREET AUDRESS, CITY, STATE, ZIP CODE 2035 \$TONEBROOK PLACE KINGSPORT, TN 37560	11/10/2013	
TEACH DEFICIENCY	TEMBRIT OF DEFICIENCES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECT	MINISTER CONTRACTOR	
probate jurisdiction estate. This REQUIREMEN by: Based on review of and interview, the faresident's funds to the ster the death of the (#170) of 56 resident	administering the resident's ' It is not met as evidenced the resident trust accounts cilly falled to convey the ne resident's family or estate a resident for one resident accounts reviewed.	F 16	manager to cond a new monthly audit of discharge residents to ensu compliance, iV. Regional accounts to audit complian	ed re ant ce	
rust accounts from a 2015, revealed Resi valance of \$376,33. Statement Register : expired on 5/13/13. Interview with the Bu at 10:55 AM, in the p scility continued to he	July 2015 through November dent #170 had a continued Continued review of the revealed the resident had singles Manager on 11/10/15 payroll office, confirmed the review with the Business	·	deceased pr	1 1	
83.25(d) NO CATHI RESTORE BLADDE lased on the resident seessment, the faci esident who enters to advelling catheter is esident's clinical con	R It's comprehensive Ity must ensure that a the facility without an not catheterized unless the Idition demonstrates that	F 818	II. All residents hat the potential to affected. Other residents in how 11/11/15 review for changes in Manages on urina	be use wed MDS	
医多二丁巴丁巴丁乌尔 计一直分子文 计时间列列码 一种名词复数	crobate jurisdiction estate. This REQUIREMENTY: Based on review of und interview, the facilitation of 56 resident for the death of the first included the finding included leview of the facility ust accounts from 015, revealed Residence of \$376,33. Itsernent Register: expired on 5/13/13. Itserview with the But 10:55 AM, in the public continued intrinued interview of the facility continued in 10:55 AM, in the public continued interview with the But 10:55 AM, in the public continued interview of the continued interview of the continued interview of the continued interview of the continued interview of the continued interview of the continued interview of the continued interview of the continued of the facility called continued in the facility called c	This REQUIREMENT is not met as evidenced by: Based on review of the resident trust accounts and interview, the facility falled to convey the esident's funds to the resident's family or estate after the death of the resident for one resident first the death of the resident for one resident first) of 56 resident accounts reviewed. The finding included: Beview of the facility's Statement Register for the fust accounts from July 2016 through November 015, revealed Resident #170 had a continued alance of \$376.33. Continued review of the statement Register revealed the resident had expired on 5/13/13. Interview with the Business Manager on 11/10/15 to 10:55 AM, in the payroll office, confirmed the resident's account one. Continued interview with the Business lianager confirmed the resident had expired on	crobate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on review of the resident trust accounts and interview, the facility fatled to convey the esident's funds to the resident's family or estate after the death of the resident for one resident fit 70) of 56 resident accounts reviewed. The finding included: Leview of the facility's Statement Register for the finding included: Leview of the facility's Statement Register for the cust accounte from July 2015 through November 015, revealed Resident #170 had a continued alance of \$376.33. Continued review of the intervent Register revealed the resident had expired on 5/13/13. Interview with the Business Manager on 11/10/15 to 10:55 AM, in the payroll office, confirmed the resident with the Business imager confirmed the resident had expired on 131/13. State of the resident interview with the Business imager confirmed the resident had expired on 131/13. State of the resident's comprehensive assessment, the facility must ensure that a sident who enters the facility without an dwelling catheter is not catheterized unless the sident's clinical condition demonstrates that whelefization was necessary, and a resident	In Business office manager to cond a new monthly audit of discharge residents to ensure the facility falled to convey the elidents funds to the resident frust accounts the facility falled to convey the elidents funds to the resident for one resident for the death of the resident for one resident for the finding included; the finding included; the finding included; the finding included; the finding included; the finding included is the resident from July 2015 through November 015, revealed Resident #170 had a continued alance of \$376.33. Continued review of the disterment Register revealed the resident had expired on \$1170.15 to 10:55 AM, in the payroll office, confirmed the expired on \$117.015 to 10:55 AM, in the payroll office, confirmed the resident had expired on \$117.015 to 10:55 AM, in the payroll office, confirmed the resident for the sustainance of \$376.33. Continued to have the resident for the sustainance of \$376.34 to 10:55 AM, in the payroll office, confirmed the resident had expired on \$117.015 to 10:55 AM, in the payroll office, confirmed the resident had expired on \$117.015 to 10:55 AM, in the payroll office, confirmed the resident had expired on \$117.015 to 10:55 AM, in the payroll office, confirmed the resident had expired on \$117.015 to 10:55 AM, in the payroll office, confirmed the resident had expired on \$117.015 to 10:55 AM, in the payroll office, confirmed the resident had expired on \$117.015 to 10:55 AM, in the payroll office, confirmed the resident had expired on \$117.015 to 10:55 AM, in the payroll office, confirmed the resident had expired on \$117.015 to 10:55 AM, in the payroll office, confirmed the resident had expired on \$17.015 to 10:55 AM, in the payroll office, confirmed the resident had expired on \$17.015 to 10:55 AM, in the payroll office, confirmed the resident had expired on \$17.015 to 10:55 AM, in the payroll office, confirmed the resident had expired on \$17.015 to 10:55 AM, in the payroll office, confirmed the resident had expired to 10:55 AM, in the payroll office, confirme	

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES MEDICAID SERVICES					FORM): 11/23/2018 1APPROVED
STATEMEN	T OF DEFICIENCES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CITA IDENTIFICATION NUMBER	(X2) 14.0 A. BUB.D	LTI	PLE CONSTRUCTION G	0	(X3) DA). 0938-0391 TE SURVEY MPLETED
		445174	B. WING	·	<u> </u>			
NAME OF	PROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CO	<u></u>	<u> 11,</u>	10/2015
BROOK	HAVEN MANOR	•	ļ	۱ :	2035 STONEBROOK PLACE			
/Y41.10	El la dada Pod mina			1	KINGSPORT, TN 37660			
(X4) ID PREFIX TAG	I EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING IN-ORMATION)	ID PREFE TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	400 E D	P-61	COMPLETION DATE
F 315	Continued From page	ne d						
	1	f bladder receives appropriate	`F3	i	III. Nursing staff			}
ļ	i neembout god 2014k	CCS to Drevent I minary tract			inserviced on			
	infections and to res function as possible	l sebbeld lemmon Hours as 910%			notification in			
		•			changes in			
ĺ	The Brainse				continence status			
	ins KEQUIREMEN	IT is not met as evidenced			11/27/15. As a ne			
	Besed on medical r	econd review and interview,			process nursing			
	THE LECTION LEGISTED TO D	For treatment and	•		supervisor will			
Ì	function as nosaible	ts much normal bladder for 1 realdent (#73) of 2			review adl flow			
j	residencs reviewed f	or urinary incontinence of 35			sheets Monday			
1	residents reviewed.				through Friday			-
ı	The findings include:	d : '			excluding holiday	_	l]
					Bladders	>.		,
- {	Medical record reviews	w revealed Resident #73 was ly on 5/21/15 with diagnoses			assessments on		- 1	1
1	ni musuk aliman Of	39truction, Congestive Meast 1			residents identifie		}	İ
	canne, joint Kepiac	ement Shoulder, Dishates 📗			-	a	ł	l
]	Mellitus Type II, Chro Disease, Aprilo Velve	onic Pulmonary Heart Disorder, Dysmetabolic			during in house review will be			-
1.	oynurome, Ostebarti	Milis. Cellulitis of Lea Modula I			· · · · · · · ·		- 1	
1	Obesity, and Depress	sion.			completed by			′
- 1	Review of the resider	nt's admission Minimum	٠.		12/1/15. Residents	3	Ì	
11	uata Set (MDS) date	d 5/29/15 revealed the			identified as		1	
{ 1	resident's Brief Inlery	few for Mental Status (RIMS)			appropriate for		- 1	
li	nas to, indicating the NECL Continued revi	resident was cognitively iew revealed the resident			bladder training w	11		
- Iv	was always continent	of bladder.	•		be started on a			
	Madical report				bladder training		ŀ	ł
.) [Madder evaluation da	v of a facility admission ited 5/21/15 revealed the			program by]	}
1 1	osident's bladder cor	TÜRERCE SCAle was			12/2/15.			
ja	essessed as complete evealed no other blace	e control. Further ravious						
0	combjeted dating the	resident's stav.					'	
	(02-99) Previous Versions Ob				-			
		C10(6 III)					et P	age 5 of 10

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	ID: 41/23/201
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIERCUA DENTIFICATION NUMBER:		TIPLE CONSTRUC	TION	OMB N (X3) D	O. 0938-039 ATE SLIRVEY DMPLETED
114 i m a 2	-	445174	B. WING		·		41600000
	PROVIDER OR SUPPLIER HAVEN MANOR			STREET ALXOR 2035 STONES KINGSPORT	ESS, CITY, STATE, ZIP CODE ROOK PLACE T. TN 37660		1/10/2015
(X/I) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRC= D TAG	PR	DVIDERIA PLAN OF CORRECTI H CORRECTIVE ACTION SHOUL REFERENCED TO THE APPRO DEFICIENCY)	DDE	COMPLETION (X2)
F 315	resident was freque (more than 7 episod 6/7/15. Continued re revealed the resider bladder from 6/8/15 8/26/15. Medical record revie summary dated 6/1/ [continent] of B/B [be occasional incontine interview with the Di 11/13/15 at 10:21 All continued the facility bladder policy. The evaluation had been admission evaluation provide treatment an	V's ADL (activities of daily for 6/2015 revealed the nity incontinent of bladder (es) from 6/1/15 through aview of the ADL Flow Record it was totally incontinent of through discharge on ew of a Nursing Weekly (15 revealed "Cont. owel and bladder] with all episodes" rector of Nursing (DON) on M, in the DON's office, odd not have a bowel and DON confirmed no bladder.	F3	15 IV.	Nursing supervisor will report to director of nursing weekly the results of the adl flow sheet for changes in bladder status x4 weeks and these weekly reports will be taken to qa. MDS will report to director of nursing any observed changes in bladder status during MDS assessments.	•	
SS¤F	aumoniies; and (2) Store, prepare, di under sanitary condit	ERVE - SANITARY sources approved or y by Federal, State or local stribute and serve food ons	F 37	1 I.	All undated drinks were immediately discarded and freshly poured by dietary staff. Ice buildup was removed immediately. All residents have the potential to be affected.		12/4/15
M CMS-256	7(02-99) Previous Vorsions Ob	colete Event ID: ZU 111	Fi	100 ID: TN8203	If anytheresis		

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES * MEDICAID SERVICES				PRINTE	D: 11/23/2016 MAPPROVED
SIATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MILT A. BUILDIN	IPLE CONSTRU	OTION	OME NI	O. 0938-0391 TE SURVEY
	<u> </u>	445174	B. WING			1	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDS	ESS, CITY, STATE, ZIP CODE	1: 11	/10/2015
BROOK	HAVEN MANOR			2035 STONE	Brook Place		
(VA) ED	Complete Comp			KINGSPOR	T, TN 27660		
(X4) ED PREFIX TAG	(CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	ID PREFIX TAG		ROVIDERS PLAN OF CORRECTION SHOULD SEED TO THE APPROXIDERCY)	T	(XII) COMPLETION DATE
	Based on facility pointerview, the facility environment for 1 of freezers observed in The findings include Review of the facility Freezers, undated, rensure safe refrigers temperatures, and stood expiration guide appropriately dated texpiration dates Use completed with expiration of the state Cook on 11/8/15 revealed the following ounce cups with clear with brown colored liquids with dark orange colored liquids with dark o	licy review, observations, and failed to maintain a sanitary 2 refrigerators and 1 of 1 if the dietary department. d: 'policy Refrigerators and everaled,"This facility will attor and freezer maintenance, smitation, and will observe elinesAll food shall be no ensure proper rotation by dates will be attors dates on all preparedRefrigerators and freezers se of debris" and alone refrigerator with at 10:34 AM, in the kitchen, yundated Items: 3 eight rilquids; 7 four ounce cups with eight ounce cups with 4 eight ounce cups with 4 eight ounce cups with 4 eight ounce cups with 5; and 6 eight ounce cups with 1; and 6 eight ounce cups with 5; and 6 eight ounce cups with 6; 2 eight ounce cups with 6; 3 eight ounce cups with 6; 4 eight ounce cups with 6; 54 AM, in the kitchen, es of powdered and frozen freezer entrance. Continued 8 of the handing plactic	F 37	IV.	Inservicing of dietary staff initiated on 11/15/15 with completion on 11/25/15 regarding dating of poured drinks. Compression P10338-1 Gasket material for repair of freezer door ordered 11/25/15. Walking rounds will be completed to ensure proper rotation by expiration dates and to ensure safe refrigerator and freezer maintenance temperatures and sanitation by dietary manager or registered dietician weekly as part of dietary sanitation		
. 11	eezer curtains at the leasuring 79 % inche	Treezer entrance					
	02-69) Previous Versions Ob	d powdered and frozen ice.				1	.
	· · · · · · · · · · · · · · · · · · ·	Event ID: 21.1111	fad	My ID: TN8203	if continuate	in sheet F	280e 7 of 10

CENTERS FOR	VIEDICARE	AND HUMAN SERVICES A MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT OF DEFICE AND PLAN OF CORRECT	ENCRES:	(X1) PROVIDER/GUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(2G) DAT	ADFELED LE SRIKAEA 1. O200-033
<u></u>		445174	B, WING	·		74	10/2015
NAME OF PROVIDER O	RSUPPLER		<u> </u>	ទា	REST ADDRESS, CITY, STATE, ZIP CODE	1 17	10/2015
erookhaven mu			_		ISS STONEBROOK PLACE INGSPORT, TN 87850		
PRÉFIX (EAC	H DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IOBATTEYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	A BE	CÓUPLETION DATE
interview Adminis the kitch maintain undated	ralor prese en, confirm a sanitary i items avail:	irector of Nursing, with the oit, on 11/8/18 at 12:40 PM, in ed the facility failed to dichen environment with able for resident consumption	F3	171	Inspection and taken to Quality Assurance committee monthly.		
F 441 483.65 II	ris in the fre NFECTION), LINENS	ezer. CONTROL, PREVENT	F4	41	F441		12/4/15
infection safe, sar to help p of diseas (a) infection The facil Program	Control Problems and control the control infection Control ity must est under which which which which control ity must est under which it is not under whi	Program ablish an Infection Control h it -			I. Resident #95 assessed with no adverse effects as result of deficient practice.	a	;
in the fac (2) Decid should be (3) Maint	ility, 88 What pro 2 applied to	trois, and prevents infections occiures, such as isolation, an individual resident; and of incidents and corrective ections.			•		
(1) When determin prevent to isolate the (2) The factor direct control (3) The factor and after a direct and a after a direct and a after a direct and a after a direct and a after a direct and a after a direct and a after a direct and a after a direct and a after a direct and a after a direct and a after a direct and a direct an	the Infection In the Infectio	ad of Infection on Control Program sident needs isolation to if infection, the facility must prohibit employees with a se or infected skin lesions with residents or their food, if insmit the disease, require staff to wash their act resident contact for which called by accepted	•			•	
W CMS-2567(02-99) Pre	riqus Vorsions C	bsolete Event ID: 21/111		l'aciti	Ly ID: TAKEZOS II continua	reerts not	Paga 8 of 10

PLAN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDERGUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MUI A. BLULO	MPLE C	ONSTRUK	TIKIN	(X3) DA	O. 0936-03 TE SURVEY
		445174	B. WING	•		·	~	, <u></u> , <u></u>
AME OF PROVIDER OR SUPPLIER				STRO	ET ADDR	ESS, CITY, STATE, ZIP CODE	1 11	/10/2015
юок	HAVEN MANOR	•	}	2035	STONES	ROOK PLACE T, TN 37650		
(4) ID REFD: TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL, BC IDENTIFYING INFORMATION)	PREFI	<u> </u>	PR	OVIDERS PLANOF CORRECTION H CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROP DEFICIENCY)	5 B-8	COMPLETIO DATE
	professional practical (c) Linens Personnel must han transport linens so a infection. This REQUIREMENT by: Based on policy revinterview, the facility disinfected after glow change for 1 of 1 reserviewed. The findings included Review of the facility Clean, undated, reverseled dress bag, 11. Dispose of good cleanse hands by we 13. Put on second part of the property of the facility of the facility clean, undated, reverseled Licenseled in the property of the facility cleanse hands by we 13. Put on second part of the property of the facility of the facility cleanseled Licenseled in the facility of the facility cleanseled Licenseled in the facility of the facility o	die, store, process and die, store, process and sa to prevent the spread of the prevent the spread of the prevent the spread of the prevent the spread of the procedure of the p	F4	41	II.	Active residents with wounds on 11/10/15 will be assessed for adverse effects by 12/4/15. Wound care competency completed with LPN #1 on 11/10/15. Weekly for 4 weeks RN will observe LPN #1 for proper disinfection after glove removal during a dressing change. Assurance committee monthly. Results will be brought to QA committee.		
<u> </u>	jioves, packed the wo jauze dressing, remo	dected hands, donned clean ound with gauze, placed a ved gloves, and without , retrieved clean gloves						

2013/025

UM CNAS-256	7(02-99) Provious Versions C	habiata Even ID: 21.1811	Facility	D: TN8203	90 sheet Page 10 of 10	
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	AM, in the halfway.	confirmed she did not after playe removal and prior				
	from the box.	PN #1 on 11/10/15 at 9:05		• •		
F 441	Continued From pa	ge 9	F 441	. Dominica(CE)		
(Xd) TO PREFIX TAG		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FLIL BC IDENTIFYINS REORMATION)	PHEFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD CHOSS REFERENCED TO THE APPROPRIENCED TO THE APPROPRIENCED TO THE APPROPRIENCY)	DDE COMPLETE	
	HAVEN MANOR	•	201	IS STONEBROOK PLACE NOSPORT, IN 37660		
NAME OF	PROVIDER OR SUPPLIER	445174	E. WING	REET ADORDES, CITY, STATE, ZIP CODE	11/10/2015	
AND PLAN	OF GORRECTION	(X1) PROVIDENSUPPLENCLA IDENTIFICATION NUMBER:	A. BUILDING_	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
CENTE	RS FOR MEDICARE TOF DEFICIENCES	& MEDICAID SERVICES			FORM APPROVED DMB_NO_0938-039	